

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011982

STATE FILE NUMBER

FILED APR 15 1959 Registration District No. 328 Primary Registration District No. 3073 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KELSO</u>		c. CITY OR TOWN <u>CHAFFEE</u> 1000	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD#1 - CHAFFEE, MO</u>		d. STREET ADDRESS (If outside, give location) <u>RFD#1</u>	
Length of stay in lb <u>24 YRS.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>RILEY</u> Last <u>BIBY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 1, 1874</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER (RET.)</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>SAWMILL</u>	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>6</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>6</u>
10a. FATHER'S NAME <u>UNKNOWN</u>		10b. BIRTHPLACE (City and state or country) <u>MONROE COUNTY, KENTUCKY</u>	
11. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. NAME OF HUSBAND OR WIFE <u>LULA BIBY</u>		14. NAME OF HUSBAND OR WIFE <u>LULA BIBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>ROBERT BIBY - RFD#1 - CHAFFEE, MO.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Peripheral Vascular Collapse</u> DUE TO (c) <u>Cardio-Vascular Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinomatosis - Primary in Sigmoid Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>422 H</u> <u>10 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>3:12</u> a.m. <u>4</u> p.m. <u>12</u> Month, Day, Year <u>1-8-1956</u> to <u>4-7-1959</u> and last saw <u>her</u> alive on <u>4-6-1959</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION <u>CHAFFEE</u>		20f. COUNTY <u>MISSOURI</u>	
21. I attended the deceased from <u>1-8-1956</u> to <u>4-7-1959</u> and last saw <u>her</u> alive on <u>4-6-1959</u> Death occurred at <u>3:12</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>H. H. Stehmer, D.O.</u>	
22a. ADDRESS <u>Chaffee, Mo</u>		22c. DATE SIGNED <u>4-7-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CHAFFEE, Missouri</u>
24. FUNERAL DIRECTOR <u>DISPENSINGHOFF FUNERAL HOME - CHAFFEE, MO</u>		25. DATE RECD. BY LOCAL REG. <u>4-8-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Paul Bragging</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Factor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

2010
459-88

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.